



Home and Community-Based Waiver MILTC-13AD, Child's Level of Care

Section 1 - Type of Waiver		
Waiver Type: EDN	Review	
Section 2 - Demographics		
Child's/Client's Name: Gardner, Elanor	Date of Birth: January 26, 2014	
Social Security Number: 978-05-4400	Medicaid pending: NO	
Medicaid Number: 234567891-01	Date Medicaid Approved: September 20, 2014	
Section 3 - Health Assessment		
Record child/client diagnosis, if known. Please state if no diagnosis has been determined.		
Diagnosis Notes: Child has cancer		
Cognitive Status: child is receiving EDN services to help keep them on track developmentally.		
Recent Height: 0 ft. 0 in. (0.0%)	Recent Weight: 0 lbs. 0 oz. (0.0%)	
Section 4 - Medical Treatments and Therapies		
Venous access/central line:	Intravenous line for long-term treatment: Can be used to give medications, IV fluids in the home, nutrients and obtaining blood specimens, or if the client has limited peripheral venous access due to extensive previous IV therapy, surgery, or previous tissue damage. Examples: broviac, hickman, groshong catheters; implanted ports (port-a-cath, infuse-a-port, norport, proshong port); PICC lines (peripheral central line).	
Justification:	Has an infusaport for IV chemotherapy every month and labwork weekly	
IV Therapies:	Daily intravenous therapy for the administration of fluids, nutrients, and/or medications. May include a main continuous intravenous infusion therapy; or an intermittent infusion device such as a heplock (for administration of periodic IV medications and solutions without continuous intravenous infusion) or an "IV Piggyback" infusion (which is used to administer medications via the fluid pathway of an established primary infusion line).	
Justification:	Receives TPN via port every night from 10pm to 6am.	
Determination of the Medical Treatments/Medical Therapies		
Client does have a medical treatment/therapy need.		
Section 5 - Activities of Daily Living (N/A 0-36 Months)		
* = Dependent		
Determination of the ADL Category		
Determination	Low	
Section 6 - Other Considerations		
* = Dependent		
Determination of Other Considerations		
Determination	Low	
Section 7 - Recommendation		
I. Medical Treatments/Therapies (1-9) Must have at least one		
Services Coordinator: Kempkes, Rebecca	Recommendation Date :	Submit Date :
Email Address: rebecca.kempkes@nebraska.gov	Phone # (402) 471-1678	
SC Agency: Good Samaritan Hospital		
Section 8 - Justification and Certification		
Justification:		
I certify that this client does not meet the criteria for NF level of care.		
Signature: ,	Certification Date :	